TO: DMS/DME Providers
Free Standing Clinics
Hospitals
Managed Care Organizations
Nurse Anesthetists
Nurse Practitioners
Nurse Midwives
Physicians
Podiatrists
Optometrists/Vision Care
Therapists

FROM: Susan J. Tucker, Executive Director, Office of Health Services
Joseph E. Davis, Executive Director, Office of Operations and Eligibility

RE: HIPAA Implementation

DATE: October 14, 2003

The Health Insurance Portability and Accountability Act (HIPAA) mandates the standardization of Electronic Data Interchange formats for health care data transmission, including claims, remittance, eligibility, and claim status inquiries. HIPAA regulations replace the electronic CMS-1500 (HCFA-1500) and UB92 claim formats, with ANSI ASC X12N 837 Transactions, version 4010A. HIPAA also requires that we accept national standard CPT, ICD-9, and HCPCS codes.

The memorandum discusses the Medical Care Programs' (the Program) HIPAA contingency plan, companion guides, testing, the Submitter Identification Form and Trading Partner Agreement, and physician billing information. **If you plan to submit electronic claims to the Program, either directly or through a billing service, you must return a signed Submitter Identification Form and Trading Partner Agreement.**

HIPAA CONTINGENCY PLAN

Claims and Remittance Advice

The Program will implement a contingency plan to continue to accept and send the current paper and electronic claims and remittance advice after the October 16, 2003 HIPAA compliance deadline. Following the Centers for Medicare and Medicaid Services (CMS) lead and announcement concerning Medicare, implementing this plan moves the Program towards

HIPAA compliance while not disrupting providers' cash flow and operations so that Program beneficiaries continue to receive the health care services they need. The authority to implement this contingency plan of processing non-compliant HIPAA electronic transactions was provided by guidance issued from Health and Human Services (HHS) on July 24, 2003.

The Program has seen low numbers of HIPAA compliant transactions tested to date. Implementing the contingency plan allows providers more time to test and successfully implement the transactions.

Providers, and their billing companies or clearinghouses, should continue to test and move towards implementation of the HIPAA standard claim and remittance advice transactions as soon as possible. Providers will be able to convert to the HIPAA standard claim transactions as soon at they have completed testing. To achieve the goal and ultimate cost savings of administrative simplification we encourage every provider to implement the HIPAA standard transactions.

Automated Medicare Electronic Crossover Claims

The Program has been testing HIPAA Coordination of Benefit (COB) claims with the Medicare Carriers and Intermediaries. The Medicare Carriers and Intermediaries will continue to send non-HIPAA compliant claims until the testing has been completed. Therefore, you should follow the existing instructions regarding submission of paper claims if you do not receive notice that the claim was automatically transferred. You should not see any difference in the processing and paying of automated Medicare crossover claims.

The Program will notify you when we begin to receive HIPAA compliant Medicare crossover claims from the Medicare Carriers and Intermediaries. The Program will not require a completed Submitter Identification Form (SIF) to process and pay Medicare crossover claims submitted from the Medicare Carrier or Intermediary under the Payer to Payer model of COB. However, to receive electronic ANSI ASC X12N 835 remittance advice a completed and signed SIF will be required.

Eligibility Verification

The Program is still testing the ANSI ASC X12N 270/271 transactions and they will not be available on October 16, 2003.

Please continue verifying a beneficiary's Medicaid eligibility by calling the Eligibility Verification System (EVS) in the metropolitan Baltimore area at 410-333-3020 or outside the Baltimore metropolitan area at 800-492-2134.

Claim Status

The Program is still developing the ANSI ASC X12N 276/277 transactions and they will not be available on October 16, 2003

For information on claim status, continue to contact the Program as you currently do: For Institutional Providers (Hospitals and Nursing Facilities), please contact the Problem Resolution Unit via phone at 410-767-5457, via fax at 410-333-5027 or in writing to Problem Resolution Unit, SS-5, 201 W. Preston St. Baltimore, MD 21201.

For all other providers, please contact Provider Relations via phone at 410-767-5503 or 800-445-1159, via fax at 410-333-7118 or in writing to Provider Relations, P.O. Box 2281, Baltimore, MD 21201

INFORMATION FOR WORKING TOWARD HIPAA COMPLIANCE

Companion Guides

In working towards the October 2003 implementation deadline, the Program produced Companion Guides to assist trading partners in understanding the ANSI ASC X12N Transactions. Our Companion Guides can be obtained through the DHMH website at: http://www.dhmh.state.md.us/hipaa/transandcodesets.html**.**

At this time, the X12 837 and X12 835 Companion Guides are available. We continue to work on the other transaction Companion Guides and will post them on the web when they are completed.

Testing

Trading Partners who plan to send electronic transmissions directly to the Program must test for HIPAA compliance before they can transmit claims to us for payment. The Program offers free testing, which can be accessed at: http://www.dhmh.state.md.us/hipaa/testinstruct.html.

Trading Partner Agreement and Submitter Identification Form

We have attached a copy of our Trading Partner Agreement and Submitter Identification Form. If you have not already done so, please return the completed forms as follows:

Pay-To Providers (Providers who receive a check directly from the State of Maryland): The Program must have both the Trading Partner Agreement and Submitter Identification Form on file before accepting any HIPAA transactions including X12N 837 (Claims).

Rendering Providers (Providers who do not receive a check from the State of Maryland, but instead receive payment through a group practice): The Program must have the Trading Partner Agreement on file before we accept any HIPAA transactions such as the X12N 270/271 (Eligibility Inquiry and Response).

Each form has a contact phone number if you have additional questions or if you are unclear which forms you are to fill out. It is imperative that you complete the necessary form(s) and return them prior to submitting electronic transactions. Please mail the agreements to:

Rita Tate
201 W. Preston St. Rm. LL3
Baltimore MD 21201
Attn: HIPAA Billing Agreements

PHYSICIAN BILLING INFORMATION

In order for Physician Billing to comply with the HIPAA, the Program is in the process of making a number of significant changes to the Physicians' Services Provider Fee Manual.

Due to unexpected difficulties, the Program will **NOT BE READY** to implement these changes on October 16, 2003. However, the remainder of this memorandum summarizes the important billing changes you can expect for anesthesia, VFC vaccine administration, and modifiers. We will send you notification when we are ready to accept claims with these changes.

Anesthesia

- Anesthesiologists and CRNA's will bill for anesthesia services using anesthesia CPT codes instead of the surgical CPT code with a modifier –30.

- The units of service reported must represent the actual time in minutes. Base units should not be reported with time units as the program automatically calculates the base units. For multiple surgeries, please bill the anesthesia code with the highest base unit value and list the actual time in minutes that extends over all procedures.

- All anesthesia claims **MUST** include one of these five modifiers to describe who rendered services and under what circumstances:
  - **AA** – Anesthesia services preformed by a physician (100 percent of calculated fee)
  - **QK** – Medical direction of two, three, or four concurrent anesthesia procedures (50 percent of calculated fee)
  - **QX** – CRNA services: with medical direction by a physician (50 percent of calculated fee)
  - **QY** – Medical direction of one CRNA by an anesthesiologist (50 percent of calculated fee)
  - or **QZ** – CRNA services: without medical direction by a physician (100 percent of calculated fee)

- Anesthesia modifiers **-47** and **-AD** are not used and; therefore, they are not payable by the Program.

- Payment for anesthesia services will be the product of the total time in minutes plus the procedure relative value units multiplied by a rate per unit and by a modifier rate.

$$(\text{Units of Service}_{\text{minutes}} + \text{Base Units}) * \text{Rate} * \text{Modifier Rate}_{(\text{All modifiers})} = \text{Reimbursement Amount}$$

The surgery code and modifier –30 will no longer be used by the Program to reimburse providers for anesthesia services.

VFC Vaccine Administration

- Healthy Kids providers will bill for administering childhood vaccines covered under the Vaccines for Children Program with the modifier -**SE** (State and/or Federally funded service), instead of the modifier –26.

The modifier -26 will no longer be used to reimburse providers for the VFC vaccine administration.

Modifiers

- The Program will recognize national modifiers.

Anesthesia		
Modifier	**Description**	**% of Listed Fee**
AA	Anesthesia performed by anesthesiologist	100
QK	Medical direction 2-4 concurrent anesthesia procedures	50
QX	CRNA service with medical direction by physician	50
QY	Medical direction of 1 CRNA by anesthesiologist	50
QZ	CRNA service without medical direction by physician	100
23	Unusual anesthesia	B.R.
Evaluation and Management		
Modifier	**Description**	**% of Listed Fee**
24	Unrelated E&M by same physician during post-op	100
25	Significant, separate E&M same physician same day	100
57	Decision for surgery same day	100
Medicine		
Modifier	**Description**	**% of Listed Fee**
26	Professional component	50-100
SE	State or Federally funded service	($10)
Radiology		
Modifier	**Description**	**% of Listed Fee**
26	Professional component	28-50

50	Procedures performed on left and right side of body	200
Surgery		
Modifier	**Description**	**% of Listed Fee**
50	Bilateral procedure	150
51	Multiple procedure	50
52	Reduced services	B.R.
53	Discontinued procedure	B.R.
54	Surgical care only	80
55	Postoperative management only	20
62	Two surgeons	100
76	Repeat procedure by same physician	100
78	Return to operating room related procedure during post-op	100
79	Unrelated procedure by same physician during post-op	100
80	Assistant surgeon	20
82	Assistant surgeon when qualified resident not available	20

- The Program will not recognize the modifier **–30**.

- The modifier **–50** will be used to report bilateral procedures and the modifier **–51** will be used to report multiple procedures. If a bilateral procedure is performed, report the bilateral procedure if available. When there is no code describing bilateral services, report the bilateral service on one claim line and add the modifier **–50**. If a procedure is identified as a bilateral procedure according to CPT, do not report the code with modifier **–50**.

- Multiple modifiers will be able to be reported. Up to two modifiers can be reported on one service line on the CMS-1500 (formerly HCFA-1500). Additional modifiers can be reported in Block 24K. Up to four modifiers can be reported in the electronic format.

Physicians' Services Provider Fee Manual

The 2003 Revision of the Physicians' Services Provider Fee Manual, an 80-page document, will be available on the internet at http://www.dhmh.state.md.us/mma/providerinfo/. Click on "Physicians' Services Provider Fee Manual - Revision 2003."